Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4054HOSA	A. BUILDING _____ B. WING _____	06/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT VIEW REGIONAL MEDICAL CENTER	360 SOUTH LOLA LANE PAHRUMP, NV 89048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 06/04/09 and finalized on 06/04/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. Complaint #NV00021451 was substantiated with deficiencies cited. (Tag #S0154) Complaint #NV00021699 was unsubstantiated. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	S 000		
S 154 SS=D	NAC 449.332 Discharge Planning 12. If, during the course of a patient's hospitalization, factors arise that may affect the needs of the patient relating to his continuing care or current discharge plan, the needs of the patient must be reassessed and the plan, if any, must be adjusted accordingly. This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to reassess and adjust	S 154		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4054HOSA	A. BUILDING _____ B. WING _____	06/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT VIEW REGIONAL MEDICAL CENTER	360 SOUTH LOLA LANE PAHRUMP, NV 89048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 154	Continued From page 1 the discharge plans of a terminal patient and provide for the transition of the patient into in-patient hospice care. (Patient #2) 1. The facility had a contract with a Hospice Group that included the transition of a terminal in-patient to in-patient Hospice care. The facility failed to reassess and adjust the discharge plan and provide the in-patient hospice care option to the patients family. Severity: 2 Scope: 1 Complaint #NV00021451	S 154		